Reset Form

Bruce A. Kanehl, D.D.S

Dental History Form

Email Form

Patient Name: _____

Preferred Name: _____

What is the purpose of today's visit?

_____

Are you having any dental discomfort or concern? _____

Previous Dentist: _____

Address: _____

Phone Number: _____

Why did you leave your last dentist?

_____

Date of last dental care: _____

Treatment rendered at that time: _____

Date of last dental x-rays: _____

How long has it been since your last teeth cleaning? _____

Do your gums bleed when you brush? _____

Do you ever have a bad taste in your mouth? _____

Do you have any loose teeth in your mouth? _____

How often do you brush? _____

How often do you floss? _____

What other dental aids do you use? (Sonicare, Braun, Proxybrush, Endtuff, etc.)

_____

Select any condition that you have had:

- ☐ Clicking or Popping of Jaw
- ☐ Grinding or Clenching Teeth ☐ AM ☐ PM
- ☐ Headaches
- ☐ Tired Jaw, especially in AM
- ☐ Teeth hit in front first
- ☐ Bad Breath
- ☐ Sensitivity to Sweets
- ☐ Food Collection between Teeth
- ☐ Pipe Smoking
- ☐ Periodontal Treatment
- ☐ Bleeding Gums
- ☐ Sensitivity to Heat
- ☐ Sensitivity to Biting Pressure
- ☐ Sensitivity to Cold

How often do you awaken with head or jaw pain of unknown origin? _____

Have you ever had an adverse reaction to or in conjunction to a medical or dental treatment? _____

If yes, please explain: _____

Have you ever been asked to Pre-Medicate prior to a dental visit? _____

Do you or your spouse snore? _____

Have you or your spouse been diagnosed with sleep apnea? _____

Are you interested in a non-surgical way to stop from snoring or treat sleep apnea? ___

How do you feel about the appearance of your teeth? _____

Are you interested in whitening your teeth? _____

Any additional information you feel might be helpful to Dr. Kanehl about your dental health? _____

Open Medical History Form Open Patient History Form Online TMJ Questionnaire Online Sleep Apnea Questionnaire